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BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE

OF THE STATE OF CALIFORNIA

IN THE MATTER OF:	DMHC No.: 04-244
Blue Cross of California	OAH No.:
Respondent.	**ACCUSATION**
	(Health & Safety Code sections 1374.34(b), 1386(b)(6),1386(b)(7) Rule 1300.74.30(h))

I.

INTRODUCTION

1. This case is brought pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended, Health & Safety Code section 1340 et seq. (the "Act"). The Accusation is based on Respondent's course of conduct regarding an enrollee diagnosed with an ovarian dermoid cyst. An in-network physician recommended a laparotomy, a major surgical procedure, and removal of the ovary as well as the cyst. The enrollee sought a second opinion from an out-of-network physician, who recommended a less invasive procedure called a laparoscopy, to be done on an outpatient basis, and involving removal only of the cyst. The enrollee submitted a grievance to the Plan seeking

approval of the less traumatic laparoscopic procedure. Respondent made misleading and deceptive statements to the enrollee, first claiming that its in-network physicians could perform laparoscopic removal of her cyst, and then offering her a "mini-laparotomy" which it falsely claimed was essentially the same as a laparoscopy. Respondent erroneously claimed to the Department of Managed Health Care's Help Center that the denial of treatment was not eligible for Independent Medical Review ("IMR"). Respondent made the further false and misleading statements to the Help Center that the same quality of care was available with an in-network provider; that Blue Cross had confirmed that the enrollee had seen one of its in-network providers; and that the physician had offered to perform the mini-laparotomy procedure.

2. By this conduct, Respondent prolonged the IMR, mischaracterized determinations substantially based on medical necessity as coverage issues, otherwise interfered with the rights of the enrollee to obtain IMR and engaged in dishonest dealing through false and inaccurate statements to the enrollee and the Department, in violation of the provisions of the Act and its implementing regulations referenced below. This constitutes cause for discipline by the Director of the Department of Managed Health Care pursuant to Health and Safety Code section 1386, subdivisions (a) and (b)(6).

II.

PARTIES

3. Amy L. Dobberteen (the "Complainant") is the Assistant Deputy Director of the Office of Enforcement in the Department of Managed Health Care. She brings this Accusation solely in that official capacity.

4. At all times pertinent to the allegations herein, Respondent has been a full-service health care service plan as defined by Health and Safety Code section 1345, subdivision (f), and is subject to the regulatory provisions of the Act.[1] Respondent is the holder of health care service plan license number 933-0303, issued on January 7, 1993 by the

[1] All references are to the Health & Safety Code unless otherwise noted.

Commissioner of the Department of Corporations, predecessor to the Director of the Department of Managed Health Care of the State of California.[2] Respondent's principal corporate office is located at 21555 Oxnard Street, Woodland Hills, California 91367.

III.

JURISDICTION

5. This Accusation is brought before the Director of the Department of Managed Health Care under the specific grants of authority contained in the following sections of the Health and Safety Code.

6. The Department is charged with the execution of California laws relating to health care service plans. Its statutory mission, as set forth in section 1341, subdivision (a), is to ensure that health care service plans provide enrollees with access to quality health care services and to protect and promote the interests of enrollees. The Director of the Department is vested with responsibility for the administration and enforcement of the Act and the rules and regulations promulgated thereunder pursuant to section 1341. Section 1386, subdivision (a) authorizes the Director to take disciplinary action against a health care service plan, including the assessment of administrative penalties against the plan, if the Director determines that the plan has committed any of the acts or omissions that are grounds for disciplinary action.

7. Among the acts or omissions that warrant disciplinary action are the following:

(a) Prolonging the IMR process, which is prohibited by Section 1374.34, subdivision (b): "A plan shall not engage in any conduct that has the effect of prolonging the independent review process";

(b) Mischaracterizing determinations substantially based on medical necessity

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[2] At the time Respondent applied for, and was granted, a license to become a health care service plan, the Department of Corporations was the regulating entity issuing licenses and enforcing the Knox-Keene Act. Effective July 1, 2000, the Department of Managed Health Care succeeded to all duties, powers, responsibilities, and jurisdiction of the Department of Corporations as they related to Corporations' Health Plan Program, Health Care Service Plans, and the Health Care Service Plan Business. (Health & Saf. Code § 1341.9).

as coverage issues ineligible for IMR, in violation of California Code of Regulations, title 28, section 1300.74.30, subdivision (h);

(c) Otherwise interfering with the right of the enrollee to obtain IMR, which is a separate violation of California Code of Regulations, title 28, section 1300.74.30, subdivision (h); and

(d) Failing to provide to the IMR organization a copy of all information used by the plan in making its decision as mandated by California Code of Regulations, title 28, section 1300.74.30, subdivision (j)(1)(B), which requires a plan to submit "a complete and legible copy of all medical records and other information used by the plan in making its decision regarding the disputed health care service."

8. Respondent committed other acts that are grounds for disciplinary action by making false representations to the enrollee and the Department, as set forth below. Such conduct warrants discipline for engaging in conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code, in violation of section 1386, subdivision (b)(7).

9. By reason of the conduct described below, Respondent is subject to disciplinary action under section 1386 and to the assessment of an administrative penalty for multiple violations of Health and Safety Code sections 1374.34(b) and 1386(b)(7) and Rules 1300.74.30(h) and (j)(1)(B).

IV.

FACTUAL ALLEGATIONS

10. The enrollee was diagnosed with an ovarian dermoid cyst. A physician at one of Respondent's contracted medical groups recommended a laparotomy, which is major surgery. The laparotomy involved a six to seven inch incision, a three to four night hospital stay, a four to six week home recovery period and removal of the ovary as well as the cyst. Seeking a second opinion, the enrollee consulted with an out-of-network physician, who

recommended a less invasive, less traumatic laparoscopic procedure. That procedure could be done on an outpatient basis, involved two or three incisions of less than an inch each, required only a five to seven day home recovery period, and would spare the ovary while removing only the cyst.

11. The enrollee thereafter submitted a grievance to Respondent seeking approval of the laparoscopic, organ-sparing procedure. Respondent denied her grievance by letter of December 30, 2003, stating:

> The removal of a Dermoid mass may be accomplished by either laparoscopy or (mini) laparotomy. Both approaches have advantages and disadvantages. With the laparoscopic approach, there may be a greater chance of rupture and spillage of the Dermoid into the body cavity. Because the contents of the Dermoid can be very irritating to the sensitive tissue ling [sic] the body, this may cause severe reactions, should complications arise. A removal by laparotomy may be a safer approach with a marginal larger incision. In addition, attempts at ovarian preservation are rarely successful and run the risk of the Dermoid returning. Thus we believe that the laparoscopy removal and ovarian preservation are not the unequivocal standard of care for Dermoids in a patient such as yourself. The recommendations by the in-network provider appear reasonable.

On this basis, Respondent claimed that the enrollee could receive "the same quality of care services" in-network, and upheld the medical group's denial of the enrollee's request for laparoscopic surgery by the out-of-network provider.

12. The out of network physician responded to Respondent's determination, to correct misstatements and misinformation, by letter of January 13, 2004. He asserted that there is ample evidence of excellent results for laparoscopic removal of dermoid cysts with less operative risk, short operating times and much faster recovery than for laparotomy, and

characterized Respondent's statements to the contrary as "incorrect and misinformed." He further asserted that there was no justification for removing the enrollee's ovary, and described Respondent's conclusion that the enrollee could receive the same quality of care from an in-network provider as false and misleading.

13. Respondent, on January 14, 2004, gave the enrollee another referral to the same in-network specialty group, asserting that the group had three physicians who could perform the less-invasive laparoscopic removal of the enrollee's Dermoid cyst.

14. However, when the enrollee attempted to schedule a consultation on January 19, 2004, the administrator in charge of booking all surgeries for the specialty medical group for the past five years said she had never heard of, nor had she ever booked, a laparoscopy or a "mini-laparotomy" procedure. The administrator further told the enrollee that none of the physicians mentioned in the letter of denial had ever performed these procedures and questioned why such a referral would ever have been made.

15. The enrollee on January 13, 2004 sought IMR of the medical necessity of the laparoscopic surgery that was not available within the HMO.

16. The Plan responded to the Department on January 16th by erroneously indicating on the Request for Health Plan Information ("RHPI") form that its denial was based on benefit/coverage rather than on medical necessity, and that therefore the dispute was not eligible for IMR. In a cover memorandum to the RHPI, Respondent misleadingly stated: "THIS MEMBER HAS BEEN AUTHORIZED FOR SURGERY WITH THE IN-PLAN PROVIDERS … ."

17. Again in a January 23, 2004 e-mail, Respondent told the Department's Help Center that the enrollee had seen another gynecologist within the specialty group, and that this doctor could perform a mini-laparotomy. That statement was false because the enrollee had not seen another physician within the group, but only her initial in-network physician, who had offered to perform a laparotomy. Moreover, because the statement named the physician, it was apparent that he was not "another" gynecologist, but the one whom the enrollee had seen initially.

18. Respondent's Medical Director subsequently represented to the Help Center by letter dated January 28, 2004 that the same quality of care was available with an in-network provider. That conclusion was said to be based on Respondent's determination that the enrollee saw an in-network provider, "and was diagnosed with a right ovarian Dermoid cyst. He recommended removal of this mass." Respondent then stated that the out-of-network provider "also recommended removal of the mass and discussed a laparoscopic (small incision) technique." That letter was misleading because it made no mention of the important distinctions between major surgery including ovarian removal, recommended by the in-network provider, and an outpatient procedure with ovarian preservation offered by the out-of-network provider.

19. As additional support for Respondent's conclusion, its Medical Director next identified three physicians at the specialty group whom he stated were "experienced in the use of a mini-lap (small incision) to remove a Dermoid." Finally, Respondent's Medical Director stated that he had confirmed with the Medical Director of the specialty group "that the member DID see another in-network OB/GYN and was advised by the physician that he has offered to perform a 'mini-laparotomy.'" (Emphasis original.) As the Department later found, all of those statements were false.

20. Respondent further made reference to enclosed pages of the Evidence Of Coverage in its letter dated January 28th, as it had in its cover memorandum to the RHPI dated January 16, 2004. Pursuant to section 1368(a)(5), such a reference is only relevant when grievances are denied on the grounds that the proposed health care services are not a covered benefit. Thus, the use of that language further indicates that the Plan continued to claim that this dispute was a coverage matter and therefore was not appropriate for IMR.

21. Based on Respondent's false representations that the enrollee had seen another physician within the medical group, who said he would perform a mini-laparotomy, and that it was equivalent to a laparoscopy, the Help Center concluded that the dispute concerned a provider choice issue and that no medical services were being denied. Accordingly, it advised the enrollee that her case would not go to IMR because no clinical issue of medical

necessity was presented. Respondent received a copy of that notice and remained silent.

22. The Department also wrote to Respondent requesting that it provide a written response to the enrollee's grievance and copies of all relevant medical records and other information the plan used in reaching its decision within five days.

23. The enrollee obtained the necessary medical services on January 28, 2004 from the out of network provider and thereafter fought to have her case reopened on the ground that IMR had been improperly denied based on Respondent's false or misleading statements. The Department again wrote to Respondent on April 7, 2004 asking for responses to the enrollee's statements, but Respondent either failed to answer the questions or provided misleading responses. For example, Respondent's letter dated April 8th avoided answering a specific inquiry, item number 2, about whether the other members of the medical group "were experienced in the use of a mini-lap (small incision)" and instead replied evasively by stating that the enrollee was issued an authorization for a consultation and "could have made an appointment with any of the providers in this group of OB/GYNs." Respondent also avoided admitting the falseness of its claim that the enrollee had obtained a second opinion from a member of the medical group, who agreed to perform a mini-laparotomy. Instead, Respondent replied misleadingly to item number 3 and stated: "it was assumed that she utilized her authorization to consult with one of the other OB/GYNs, who could perform the 'mini-laparotomy.'" By its nonresponsive replies and affirmative misstatements, Respondent continued to resist and prolong IMR and to mischaracterize a medical necessity issue as a coverage question.

24. Again on May 18, 2004, Respondent made affirmative misleading representations to the Department. In a memorandum sent by facsimile, Respondent misrepresented the factual background of this dispute and said, referring to inquiry tracking notes of calls made by the enrollee to Respondent: "I think these notes really clarify what happened. Basically the member saw [the in-network provider] on December 8, 2003. After that the member searched the internet and saw [the out-of-network provider] and (self-referred) on or about December 10, 2003." By its affirmative misstatements, Respondent

continued to mischaracterize a medical necessity issue as a coverage question, thereby avoiding IMR, by making it appear that the enrollee simply desired another provider and there were no differences in medical treatment offered.

25. After a 120-day delay, the enrollee succeeded in persuading the Help Center to reopen her case for IMR on May 18th. As the Department found, Respondent made factually inaccurate and misleading statements to it, which resulted in the closing of the enrollee's IMR application. It further found that the matter did involve an issue of medical necessity and was therefore appropriate for IMR.

26. Nevertheless, Respondent continued to make incorrect and misleading statements to the reviewing entity, The Center for Health Dispute Resolution ("CHDR"). In a letter dated May 19th to CHDR, Respondent contended that a mini-laparotomy is essentially the same operation as a laparoscopy, and possibly a more appropriate treatment. This representation ignored the facts that the mini-laparotomy being offered by the plan was more similar to major surgery in terms of length of incision and recovery time, and involved the removal of an ovary, which the laparoscopy did not. It also failed to disclose that the specialty group had refused to schedule an appointment for the enrollee, on the grounds that no in-network provider had ever performed a mini-laparotomy procedure. Respondent had the opportunity, and indeed the obligation, to submit to CHDR a copy of any other relevant documents or information used in determining whether health care services should have been provided, and any statements explaining the reasons for denying medical services pursuant to section 1374.30(n)(1)(B)(3) and was specifically asked to do so by the Department in its letter of January 27, 2004.

27. Moreover, despite the fact that the Help Center wrote to Respondent on June 4, 2004, giving it another opportunity to explain the reasons for the misleading statements in its letter of January 28, the Plan failed to do so. Instead, in a letter dated June 14, 2004, Respondent claimed that a physician from the specialty group had said that the member had already seen a physician there, ostensibly relying on a handwritten note saying that the doctor "will find a GYN who is trained in laparoscopic removal." Additionally, Respondent

continued to claim that the enrollee's contentions were incorrect and reiterated the false assertion that material faxed from the medical group refuted the enrollee's allegation that the group physicians were not receptive to discussion of a small incision removal of her cyst.

28. The enrollee subsequently prevailed in IMR about June 10, 2004. The CHDR reviewer concluded that the laparoscopy was medically necessary because it was less invasive and had a shorter recovery time than either the laparotomy or mini-laparotomy offered by the plan to the enrollee. The reviewer further noted that based on the recovery time stated in the informed consent given by the provider who recommended the mini-laparotomy, his definition of mini-laparotomy was akin to a more major procedure. The Department so informed Respondent, and only then did it reverse its previous denial and approve coverage under the enrollee's HMO benefits for the laparoscopic surgery she had on January 28, 2004.

29. By the conduct described in the foregoing paragraphs, Respondent failed to provide information to support the asserted equivalency of a mini-laparotomy to a laparoscopy, relied on by the Plan in making its decision; prolonged the IMR process and otherwise interfered with the right of the enrollee to obtain IMR. Respondent also engaged in a practice of mischaracterizing determinations substantially based on medical necessity as coverage issues over a six-month period.

V.

FIRST CAUSE FOR DISCIPLINE

(Prolonging and Otherwise Interfering with IMR)

30. Complainant incorporates the provisions of paragraphs 1, 2, 4, 10, 11, 13 through 24 and 27 above, and realleges them as though fully set forth herein.

31. Respondent is subject to an administrative penalty for jeopardizing the enrollee's right to obtain a review of her health plan's denial of services by independent medical review personnel, who determine whether the requested treatment is medically necessary, in violation of the Act's provisions governing IMR in the following respects:

(a) Respondent's conduct prolonged the IMR process for 120 days in violation of section 1374.34, subdivision (b);

(b) Respondent opposed IMR, denied that the enrollee was entitled to IMR, and otherwise interfered with the right of the enrollee to obtain IMR in violation of California Code of Regulations, title 28, section 1300.74.30, subdivision (h).

(c) Respondent failed to provide to the IMR organization a complete and legible copy of all information used by the plan in making its decision regarding the disputed health care service as required by California Code of Regulations, title 28, section 1300.74.30, subdivision (j)(1)(B), thereby further interfering with the right of the enrollee to obtain IMR in violation of section 1300.74.30(h).

(d) Respondent engaged in a practice of mischaracterizing determinations substantially based on medical necessity as coverage issues on the RHPI form and cover memorandum dated January 16, 2004; in a January 23, 2004 e-mail and in its letters dated January 28, 2004, April 8, 2004, May 19, 2004, and June 14, 2004; thereby again violating California Code of Regulations, title 28, section 1300.74.30, subdivision (h).

VI

SECOND CAUSE FOR DISCIPLINE

(Dishonest Dealing)

32. Complainant incorporates by reference the provisions of paragraphs 1, 2, 4, 10, 11 through 27 and 29 and realleges them as though fully set forth herein.

33. Respondent is subject to an administrative penalty for violation of the Act's provisions prohibiting dishonest dealing because it made a number of factually inaccurate

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and misleading statements to the enrollee and to the Department over a number of months, in the following respects:

(a) On December 30, 2003, Respondent misrepresented to the enrollee that the services it offered to her were equivalent to a laparoscopic procedure and that it could provide the same quality of care services in-network.

(b) On January 14, 2004, Respondent misrepresented that its specialty medical group had three physicians who could perform laparoscopic removal of Dermoid cysts.

(c) Respondent misrepresented that its specialty medical group had other specialists who could provide a mini-laparotomy, which was a comparable procedure to a laparoscopy.

(d) On January 16, 2004, Respondent made a misleading statement to the Department in its cover memorandum to the RHPI by asserting that the enrollee had been authorized for surgery with the in-plan providers, without explanation, qualification, or limitation.

(e) In an e-mail message dated January 23, 2004, Respondent misrepresented to the Department that the enrollee had seen another physician within the medical group and that he could perform a mini-laparotomy.

(f) By letter dated January 28, 2004, Respondent made misrepresentations to the Department that the same quality of care was available with an in-network provider, and deceptively claimed that both the in-network and out-of-network provider "recommended removal of this mass" without disclosing that the in-network provider recommended removal of the cyst and ovary, through in-patient, major surgery, and the out-of-network provider recommended removal only of the cyst on an outpatient basis.

(g) In the letter of January 28, 2004, Respondent further made misrepresentations to the Department, that three physicians at the specialty group were experienced in the use of "a mini-lap (small incision)" procedure to remove a Dermoid cyst and that he had confirmed with the Medical Director of the specialty group that the enrollee had seen one of their physicians and that the physician had offered to perform a mini-laparotomy.

(h) Respondent's letter of April 8, 2004 to the Department gave several evasive and non-responsive replies to the Department's inquiries, and misleadingly stated that the enrollee could have made an appointment, and that "it was assumed" that she had done so and that the other physician could perform the mini-laparotomy procedure.

(i) Respondent again made misleading representations to the Department in a memorandum dated May 18, 2004, in which it misrepresented the factual background of the dispute and suggested the enrollee simply chose another provider for personal reasons.

(j) Respondent's May 19, 2004 letter continued to erroneously assert to CHDR that it denied the laparoscopy because the mini-laparotomy that it offered was essentially the same operation.

(k) Respondent continued to make misrepresentations to the Department in its letter of June 14, 2004, which again incorrectly asserted that a physician from the specialty group had said that the enrollee had already seen a physician there, and falsely stated that the enrollee's contentions were incorrect and that material from the medical group refuted the enrollee's allegation that the group physicians were not receptive to discussion of a small incision removal of her ovarian cyst.

These acts and conduct constitute dishonest dealing, as well as unlawful, unfair or fraudulent acts proscribed by Business & Professions Code section 17200. The Department may

impose administrative penalties for these acts and conduct pursuant to Health & Safety Code section 1386, subdivision (b)(7).

VII.

DISCIPLINARY CONSIDERATIONS

34. The Director of the Department has the discretion, pursuant to the provisions of the Health and Safety Code, section 1386, subdivision (a), to assess administrative penalties as well as to suspend or revoke the license of a health care service plan for violations of the Act.

35. Complainant has considered the following factors in seeking an assessment of an administrative penalty of $120,000 against the Respondent in this action:

(a) This matter involves serious and egregious conduct. Respondent engaged in a continuing course of misconduct involving false and incorrect representations and misleading statements to the enrollee and the Department over a six-month period. The Plan repeatedly claimed that another provider had seen the enrollee and offered to perform a mini-laparotomy, both of which were untrue.

(b) Respondent's conduct was in bad faith; it mischaracterized the issue as involving coverage, rather than medical necessity, repeatedly refused to acknowledge the accuracy of the enrollee's contentions, and repeated its misrepresentations to the Department that it had offered equivalent services to the enrollee in network.

(c) Respondent's claim that equivalent services were offered the enrollee was false and was rejected in IMR. The reviewer specifically found, based on the recovery time stated in the informed consent given by the provider who recommended the mini-laparotomy, that it was akin to a more major procedure.

(d) Respondent's violation of the Act is not an isolated incident. On December 17, 2003, the Plan agreed to pay a $50,000 penalty for prolonging the IMR process in enforcement matter number 03-121. That matter involved the Plan's failure to authorize payment for services rendered, which had been found to be medically necessary by IMR.

(e) Respondent did not cooperate with the Department, but rather obfuscated the issues by repeatedly responding to the Department's inquiries with false and misleading information.

(f) Respondent is one of the largest health care service plans in the State of California, with 4,609,205 enrollees, total annual revenues of $2,666,819,000, and net annual income of $157,997,000 as of September 30, 2004.

(g) The financial penalty necessary to deter similar violations in the future is the sum of $120,000. Respondent can sustain this penalty amount because it is only .00444 percent of the Plan's annual revenues of $2.7 billion as of September 30, 2004.

PRAYER

THEREFORE, complainant prays that a decision be rendered by the Director of the Department of Managed Health Care assessing an administrative penalty in the amount of $120,000 against Respondent, for the commission of the multiple violations of the Act and

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regulations alleged in this Accusation, and for such other and further relief as the Director deems proper.

Dated: April 29, 2005

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Patricia Sturdevant

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